

AARP Medicare Supplement Plans

Your Plan

**NOTE: PLAN J IS A CLOSED PLAN			
	Plan F	Plan K	Plan J**
Medicare Part A Coinsurance hospital costs up to an additional 365 additional days after Medicare benefits end	100%	100%	100%
Medicare Part B Coinsurance or Copayments	100%	50%	100%
Blood (First 3 Pints)	100%	50%	100%
Hospice Care Coinsurance or Copayment	100%	50%	
Skilled Nursing Facility Care Coinsurance	100%	50%	100%
Medicare Part A Deductible	100%	50%	100%
Medicare Part B Deductible	100%		100%
Medicare Part B Excess Charges	100%		100%
Foreign Travel Emergency (Up to Plan Limits)	100%		100%
At-Home Recovery (Up to Plan Limits)			100%
Preventive Care not Covered By Medicare (up to \$120)			100%
Annual Out-of-Pocket spending limit		\$4,620	



UnitedHealthcare

¹ Exception: Plans K and L will pay 100% of Part B co-insurance for preventive services covered by Medicare

Medicare Select - Plan F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**** You must use a Network Hospital.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* in a Network Hospital**** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: – While using 60 lifetime reserve days – Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	All but \$1,100 All but \$275 a day All but \$550 a day \$0 \$0	\$1,100 (Part A Deductible) \$275 a day \$550 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Medicare Select - Plan F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed \$155 of Medicare-approved amounts for covered services

(which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**** You must use a Network Hospital.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT**** , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$155 (Part B Deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$155 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$155 (Part B Deductible) 20%	\$0 \$0 \$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

Plan K

* You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$4620 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: – While using 60 lifetime reserve days – Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$1,100 All but \$275 a day All but \$550 a day \$0 \$0	\$550 (50% of Part A Deductible) \$275 a day \$550 a day 100% of Medicare eligible expenses \$0	\$550 (50% of Part A Deductible)♦ \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$68.75 a day \$0	\$0 \$68.75 a day♦ All costs
BLOOD First 3 Pints Additional amounts	\$0 100%	50% \$0	50%♦ \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance♦

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan K

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

**** Once you have been billed \$155 of Medicare-approved amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$155 of Medicare Approved Amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$0 Generally 80% or more of Medicare Approved Amounts Generally 80%	\$0 Remainder of Medicare Approved Amounts Generally 10%	\$155 (Part B Deductible)****♦ All costs above Medicare Approved Amounts Generally 10%♦
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$4620)*
BLOOD First 3 Pints Next \$155 of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50%♦ \$155 (Part B Deductible)****♦ Generally 10%♦
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$4620 per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$155 of Medicare Approved Amounts***** Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 10%	\$0 \$155 (Part B Deductible)♦ 10%♦

***** Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.